Va. DMHMRSAS Pharmacy, Therapeutics Formulary Committee
Nonformulary Medication Request Form

Section I: (Prescriber)

Date: _____ **Pharmacist receiving request**:_____

Medication Requested:

_____

Dosage Form and Strength:

_____

Estimated Duration of Therapy:

_____

Patient's Name: _____

Patient's MRN (SSN): _____

Associated CSB_____

Ordering Physician: _____

Physician's Beeper No./ contact information: _____

Section II: Clinical Justification (Prescriber):

Patient has a documented adverse reaction to the formulary medication. Please document the offending agent and the reaction below.

_____
_____
_____

Newly marketed medication that has not been considered for formulary addition AND patient has experienced a documented therapeutic failure with formulary agents. Please document the medications and doses used below.

1)_____
2)_____
3)_____

This form is used to request a Non Formulary Medication to the Va. DMHMRSAS PT&F Formulary. Non Formulary requests may only be requested by CSB physicians, facility prescribers or pharmacists, or through needs identified by the Pharmacy, Therapeutic & Formulary Committee.

We reserve the right to return this form to the petitioner if all portions of this form are not completed.

Completed forms: forward to the Community Resource Pharmacy (pharmacy retain original), Attn: Pharmacy Manager; Box 4030, Petersburg, VA. 23803. Send copies to Central Office, Attention: Medical Director / Clinical Pharmacy Services; fax (804) 786-8623, Va. DMHMRSAS or Mail: Medical Director / Clinical Pharmacy Services, DMHMRSAS; Jefferson Bldg; 1220 Bank Street, Richmond, VA. 23220 MEDIS

Section II: Clinical Justification (Prescriber [cont.]):

Patient stabilized on a specific non-formulary medication. Please explain below.

_____
_____
_____
_____

Other justification. Please explain below.

_____
_____
_____
_____

Section III: Review (Pharmacy / PTF Committee):

Physician Contacted [Y/N]: _____ Date/Time: _____ Pharmacist name_____
Physician Contacted [Y/N]: _____ Date/Time: _____ Pharmacist name_____
Physician Contacted [Y/N]: _____ Date/Time: _____ Pharmacist name_____

Formulary Medication(s) Recommended [Y/N]? Name[s] and suggested dose:

_____
_____
_____

Recommendation accepted.
Recommendation denied, a formulary medication to be dispensed.
If Non formulary recommendation is denied, document rationale below.

_____
_____
_____
_____
_____
_____

Section IV: Approval to Dispense Obtained for thirty days, (maximum 6 months): (Pharmacy / PTF Committee):

Director / Manager, Department of Pharmacy Services or Designee How long? _____

Medical Director, Pharmacy and Therapeutics Committee or Designee How long? _____

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